Senior's Health Benefit Claim Form

Member Information		
Last Name	First Name	Member Number
Address		
City	Province	Postal Code
Phone Number	Email Address	

Claim Details	Claim Code: Member = 00 Spouse/Partner = 01			
Claimant's Name	Claim Code	Claim #	Claim Item (from the list below)	Amount Claimed
			TOTAL	

(please ensure that all expense receipts and medical recommendations are attached)

By signing this form, I understand that UBCP/ACTRA may check the accuracy of the information given in support of my claim.

I certify that all goods and services being claimed have been received by me, or my eligible spouse/partner. I certify that the information in this form is true and complete and does not contain a claim for any expense previously paid for by this or any other plan.

I authorize UBCP/ACTRA, its agents and service providers to use and exchange information about me needed for adjudicating this SHB claim with any other person or organization that has relevant information pertaining to this claim including health professionals, institutions, investigative agencies, insurers and reinsurers. I understand that information pertaining to this claim may be reviewed in the event this program is audited.

By submitting this form, I understand that I am requesting payment be made for the above expenses, in accordance with my Seniors Health Benefit. I accept full responsibility for ensuring that all expenses incurred and submitted for payment from my Seniors Health Benefit are allowable medical expenses as detailed in the attached **UBCP/ACTRA LIST OF ELIGIBLE EXPENSES**.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original.

Claimant Signature (required): _____ Date: _____

UBCP/ACTRA Authorization (required): _____ Date: _____

UBCP/ACTRA has compiled the following list of eligible expenses for the Seniors Health Benefit Program. This list is based on the Canada Revenue Agency (CRA) guidelines.